04-265

USAID GRANT AGREEMENT NO. 497-0393

and

USAID/WASHINGTON PROJECT NO. 498-0001

# STRATEGIC OBJECTIVE GRANT AGREEMENT

# BETWEEN THE

# REPUBLIC OF INDONESIA

# AND THE

# UNITED STATES OF AMERICA

# FOR

# PROTECTING THE HEALTH OF THE

# MOST VULNERABLE WOMEN AND CHILDREN

Certified to be a true copy of
the original signed by

DATED: 8/13/99

James A. Hope, Deputy Program Director
October 11, 2002

This STRATEGIC OBJECTIVE GRANT AGREEMENT, is entered into between the REPUBLIC OF INDONESIA ("Grantee") and the UNITED STATES OF AMERICA, acting through the U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT ("USAID").

WHEREAS, the Grantee and USAID ("Parties") hereby express their continued commitment to the goal of Protecting the Health of the Most Vulnerable Women and Children as described herein,

WHEREAS, the Grantee and USAID hereby affirm their financial, in-kind and other commitments and understandings made pursuant to the goal of Protecting the Health of the Most Vulnerable Women and Children,

WHEREAS, in order to focus and strengthen the efforts of the Parties in preserving essential services, improving crisis monitoring and surveillance and promoting appropriate health behaviors to protect the health of women and children,

WHEREAS, USAID's Washington headquarters have created a regional project entitled, Accelerating Economic Recovery in Asia (Project No. 498-0001), through which additional resources are being made available to support the objectives contained in this agreement,

NOW, THEREFORE, the Parties hereby agree as follows:

Article 1: Purpose

Section 1.1. The purpose of this Strategic Objective Grant Agreement (hereinafter referred to as the "Grant Agreement" or "Agreement"), is to set out the commitments and understandings of the Parties about the Strategic Objective described below.

Section 1.2. The title of this Agreement is "Protecting the Health of the Most Vulnerable Women and Children."

Article 2: Strategic Objective and Results

Section 2.1. Strategic Objective. The Strategic Objective is To Protect the Health of the Most Vulnerable Women and Children (the "Objective").

Sec 2.2. Results. In order to achieve the Objective, the Parties agree to work together to achieve the following significant results ("Results"):

a) Essential health services are preserved (essential health services are defined as: family planning; maternal and neonatal health; child health and nutrition; HIV/AIDS and sexually transmitted infection prevention);

b) Crisis monitoring and disease and nutritional surveillance are improved to enhance appropriate responses; and

c) Appropriate services and behavior are promoted to mitigate crisis impact.

Indicators by which achievement of these results will be measured and quantified will be specified in a separate Implementation Letter. Within the limits of the definition of the objective in Section 2.1, the Results stated above may be changed by written agreement of the authorized representatives of the Parties without formal amendment of this Agreement.

Section 2.3. Annex 1, Amplified Description. Annex 1, attached, amplifies the above Strategic Objectives and Results. Within the limits of the above definition of the Objective in Section 2.1, Annex 1 may be changed by written agreement of the authorized representatives of the Parties without formal amendment of this Agreement.

Article 3: Contributions of the Parties

Section 3.1. USAID Contribution.

(a) The Grant: Current Increment. To help achieve the Objective and Results set forth in this Agreement, USAID, pursuant to the Foreign Assistance Act of 1961, as amended, hereby grants to the Grantee under the terms of the Agreement an increment not to exceed Fifteen Million Five Hundred Thousand United States ("U.S.") Dollars ($15,500,000). The increment not to exceed Six Million Five Hundred Thousand U.S. Dollars ($6,500,000) provided under the Accelerating Economic Recovery in Asia project, is hereby incorporated in this Agreement.

b) Total Estimated USAID Contribution. USAID's total estimated contribution to the achievement of the Objective and Results will be Seventy Million U.S. Dollars ($70,000,000), which will be provided in increments. Subsequent increments will be subject to the availability of funds to USAID for this purpose and the mutual agreement of the Parties, at the time of each subsequent increment, to proceed.

c) Fiscal Year Reductions. If at any time USAID determines that its contribution under Section 3.1(a) exceeds the amount which reasonably can be committed for achieving the Objective and Results or activities during the current or next U.S. fiscal year, USAID may, upon written notice to the Grantee, withdraw the excess amount, thereby reducing the amount of the Grant as set forth in Section 3.1(a). Actions taken pursuant to this subsection will not revise USAID's total estimated contribution set forth in 3.1(b)."

Section 3.2. Grantee Contribution

Due to the economic crisis, a twenty-five percent (25%) host country contribution will not be required by the Government of Indonesia under this Agreement. The Government of Indonesia agrees, however, to supply contributions on an in-kind basis which are judged vital to the achievement of the Objective and Results under this Agreement. Such in-kind contributions may include office space, utilities, salaries of official Government of Indonesia counterparts, pharmaceuticals, vitamins, medical equipment and supplies, customs, transportation fees, and other program related commodities. The Government of Indonesia agrees to report in-kind contributions to USAID on a quarterly basis.

Article 4: Completion Date

(a) The Completion Date, which is September 30, 2003, or such date as the Parties may agree to in writing through Implementation Letters is the date by which the Parties estimate that all the activities necessary to achieve the Objective and Results will be completed.

(b) Except as USAID may otherwise agree to in writing, USAID will not issue or approve documentation which would authorize disbursement of the Grant for services performed or goods furnished after the Completion Date.

(c) Requests for disbursement, accompanied by necessary supporting documentation prescribed in Implementation Letters, are to be received by USAID no later than nine (9) months following the completion date or such other date as USAID agrees to in writing before or after such period. After such period USAID, at any time or times, may give notice in writing to the Grantee and reduce the amount of the grant by all or any part thereof for which requests for disbursement, accompanied by necessary supporting documentation prescribed in Implementation Letters, were not received before the expiration of such period.

Article 5: Conditions Precedent to Disbursement

Section 5.1. First Disbursement

Prior to the first disbursement under the Grant, or to the issuance by USAID of documentation pursuant to which disbursement will be made, the Grantee will, except as the Parties may otherwise agree in writing, furnish to USAID in form and substance satisfactory to USAID, a statement in the name of the persons holding or acting in the office of the Grantee specified in Section 7.5. Representatives, together with a specimen signature of each person identified in such statement.

Section 5.2. Notification

USAID will promptly notify the Grantee when USAID has determined that condition precedent regarding specimen signatures has been met.

Section 5.3. Terminal Date for Conditions Precedent

The terminal date for meeting the condition specified in Section 5.1 is 45 days from the date of this Agreement or such later date as USAID may agree to in writing before or after the terminal date above. If the condition precedent in Section 5.1 has not been met by the above terminal date, USAID, at any time, may terminate this Agreement by written notice to the Grantee.

Article 6: Special Covenants

Section 6.1. USAID Standard Provision F.1. Job Loss, Export Processing Zones and Worker's Rights.

After a thorough review, the Parties have determined that the activities proposed for funding under this Agreement do not in any way relate to the Standard Provision F.1. of Annex 2. Should potential issues arise in the future under this Agreement, the Parties agree to work together to resolve any concerns related to Standard Provision F.1. of Annex 2.

Section 6.2. Salaries of Government Officials

The Grantee agrees that no individuals paid salaries from funds provided under this Agreement will, at the same time, draw a Government of Indonesia salary except with prior written approval by USAID.

Section 6.3. Tax and Duty Free Status

The Grantee, in conjunction with the appropriate Government of Indonesia ministries and offices, will ensure exemptions on the import, export, purchase, use or disposition of any equipment or property financed, leased or imported with USAID funding under this Agreement from taxes, including Value Added Taxes, duties, and fees, of whatever nature charged in Indonesia.

Section 6.4. Tax Free Salaries

The Grantee, in conjunction with the appropriate Government of Indonesia ministries and offices, will ensure exemptions from income taxes and other such national fees or contributions levied pursuant to the laws of Indonesia for all individuals, except citizens and permanent residents of Indonesia, who are employed (whether direct hire, contract, grant or other arrangement) by USAID or by any organization financed by USAID to perform work in connection with this Agreement.

Section 6.5. Clearing and Transport Costs for USAID-financed Project Commodities

The Grantee, in conjunction with the appropriate Government of Indonesia ministries and offices, agrees to pay all costs related to clearing USAID-funded project commodities and equipment, including contraceptives, through Indonesian customs, and transporting commodities and equipment funded or partially funded under this Agreement.

Section 6.6 Visas and Assignment Approvals

The Grantee, in conjunction with the appropriate Government of Indonesia ministries and offices, will ensure the prompt and timely approval and issuance of visas and assignment approvals for individuals working for partner organizations receiving USAID financing in furtherance of the Objective and Results.

Article 7: Miscellaneous

Section 7.1 Maintenance of Records

The Grantee shall maintain, or cause to be maintained, in accordance with generally accepted accounting principles and practices consistently applied, such books and records and underlying documentation relating to this Agreement as are necessary to show adequately, without limitation, compliance with these Agreements. Such books and records will be audited regularly in accordance with generally accepted auditing standards, and shall be maintained for three (3) years after the completion date.

Section 7.2. Inspections and Audits

The Grantee will afford authorized representatives of USAID the opportunity at all reasonable times to inspect the books, records and other documents maintained by the Grantee relating to this Agreement. Notwithstanding the provisions of this paragraph, USAID reserves its rights with respect to audits of records, documents and accounts which will not be infringed by arrangements for audits by the Grantee or by arrangements for audits by independent auditors.

Section 7.3. Implementation Letters

Implementation Letters will be issued under this Agreement from the date of this Agreement. The Parties may use these Implementation Letters to confirm and record additional understandings and commitments related to this Agreement. Implementation Letters may not be used to amend the text of this Agreement, but can be used to record revisions or exceptions which are permitted by the Agreement, including the revision of elements of the Amplified Description and budget as set forth in Annex 1. Implementation Letters shall be binding on the Parties unless revoked, modified, or superseded by subsequent Implementation Letters or amendments to this Agreement.

Section 7.4. Communications

Any notice, request, document, or other communication submitted by either Party to the other under this Agreement will be in writing or telefax, and will be deemed duly given or sent when delivered to such Party at the following address:
To USAID:

Mailing Address:
Office of Population, Health and Nutrition
USAID
Jl. Medan Merdeka Selatan No 3-5
Jakarta 10110, Indonesia

Fax:
Office of Population, Health, and Nutrition
021-380-6694

To the Grantee: Ministry of Health
Mailing Address:
Jl. H.R. Rasuna Said Blok X5, Kav. 4-9, 2nd. Flr.
Jakarta

Fax: (62-21) 520-1591 (Phn & Fax)
(62-21) 522-3017

To the Grantee: Ministry of Population, BKKBN
Mailing Address:
Jl. Permata 1
Halim Perdanakusuma
Jakarta Timur 13650

Fax: (62-21) 809-4702

All such communications will be in English, unless the Parties otherwise agree in writing. Other addresses may be substituted for the above upon the giving of notice.

Section 7.5. Representatives

For all purposes relative to this Agreement, the Grantee will be represented by the individual holding or acting in the office of the Minister of Health and the individual holding or acting in the office of State Minister of Population/Chairman of BKKBN. USAID will be represented by the individual holding or acting in the office of the Mission Director, USAID/Indonesia. Each of whom, by written notice, may designate additional representatives for all purposes other than

signing formal amendments to the Agreement. The names of the representatives of the Grantee, with specimen signatures, will be provided to USAID, which may accept as duly authorized any instrument signed by such representatives in implementation of this Agreement, until receipt of written notice of revocation of their authority.

Section 7.6. Standard Provisions Annex

A Standard Provisions Annex is attached to and forms part of this Agreement. Standard Provisions are found in Annex 2.

IN WITNESS WHEREOF, the Republic of Indonesia and the United States of America, each acting through its duly authorized representative, have caused this amendment/Strategic Objective Grant Agreement to be signed in their names and delivered as of the day and year first above written.

REPUBLIC OF INDONESIA

Prof. Dr. Farid A. Moeloek
Minister of Health

Drs. Sardin Pabbadja
Vice-Chairman
National Family Planning Coordinating Board

UNITED STATES OF AMERICA

Desaix B. Myers
Mission Director
USAID/Indonesia

8/13/95

# *ANNEX 1*

# *AMPLIFIED DESCRIPTION*

## *Protecting the Health of the Most Vulnerable Women and Children*

## *USAID/Indonesia*

# ANNEX 1. AMPLIFIED DESCRIPTION
# PROTECTING THE HEALTH OF THE
# MOST VULNERABLE WOMEN AND CHILDREN

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ANNEX I

AMPLIFIED STRATEGIC OBJECTIVE DESCRIPTION

PROTECTING THE HEALTH OF THE MOST VULNERABLE WOMEN AND CHILDREN

## 1. Purpose

This Annex provides an amplified description of the new USAID/Indonesia Strategic Objective: "Protecting the Health of the Most Vulnerable Women and Children," the type and scope of activities to be undertaken for this program, and the results to be achieved with the funds obligated under the Strategic Objective Agreement (referred to as the "Agreement"). Nothing in this Annex shall be construed as amending any of the definitions or terms of the Agreement.

## 2. Background

As a result of the economic crisis in Indonesia which began in mid-1997, USAID redefined its overall country program strategy in Indonesia for the next five years. A new strategy was designed to focus efforts on mitigating the impact of the crisis for the next two years (1999 - 2000) and to provide support over the longer-term (2001 - 2003) on strengthening and sustaining institutions in order to create a favorable environment for crisis recovery. One of USAID's five new strategic objectives is "To Protect the Health of the Most Vulnerable Women and Children." Strategic Objectives are broader in scope than projects previously had been, and provide a mechanism for ensuring that activities work together toward a common purpose, and that all activities supported by USAID contribute to specified objectives. Results necessary for achieving objectives are identified, and activities necessary for results are grouped into "Intermediate Results."

The program described herein provides a comprehensive articulation of the synergistic relationships among all activities supported under USAID's new strategic objective of Protecting the Health of the Most Vulnerable Women and Children. This Annex describes the new strategic objective, the type and scope of activities to be undertaken, and the results to be achieved with the funds under this Agreement.

### Section 2.1: Problem: Impact of Crisis on Health Status and Health Care

Indonesia is enmeshed in a complex crisis with mutually reinforcing political, economic and social dimensions. The sudden onset of the crisis and the scale of the changes it has brought have created uncertainties and extraordinary challenges. Dramatic social consequences due to the political and economic crises have led to the need for an effective Social Safety Net to

mitigate the impact of the crisis on the health of the most vulnerable segments of the population: women and children.

The conditions underlying the economic crisis have led to both a *health crisis* and a *health care crisis* which threaten to damage the gains that Indonesia has made in building a strong health care system in both public and private sectors. The economic crisis threatens impressive gains made over the past 25 years in reducing fertility and child mortality, including infant and neonatal mortality. The crisis also threatens to exacerbate an unacceptably high level of maternal mortality. The crisis may also exacerbate the spread of sexually transmitted infections, including HIV/AIDS.

The economic crisis is having a devastating impact on *health status* largely due to the drop in real income and purchasing power of Indonesian households to pay for the goods and services that directly influence health status: food, preventive and curative health care services, medicines, contraceptives, sanitation, and education.. Purchasing power has been reduced by both a reduction in the nominal level of income (due to rising unemployment, which has increased about four-fold this year), and a doubling of the food price index and 65 percent increase in the general consumer price index since December 1997. In addition, the cost of pharmaceuticals and contraceptives has increased dramatically since December 1997. Lower incomes and higher prices have resulted in substantial increases in the number of households that are living in poverty.

Expected impacts on the determinants of health status are the following:

- Reduced food consumption has resulted in severe nutritional and micronutrient deficiencies, particularly for women and children under age five.

The rising level of food insecurity has resulted in reduced average caloric consumption and also in lower quality diets. Maternal malnutrition, a critical factor in morbidity and mortality for mothers and their newborn children, is increasing. There is documented evidence of a decline in the Body Mass Index (BMI) for women in Jakarta, Surabaya, and parts of Central Java over the past year. Consumption of expensive micronutrient rich food items like meat, milk and eggs has decreased which has led to severe increases in iron-deficiency anemia among Indonesian women and children. In some large urban areas and parts of Central Java, anemia among women has more than doubled since mid-1997. In low income areas of Jakarta, approximately 88% of the women surveyed are anemic.

The current economic crisis has also caused an increase in vitamin A deficiency, particularly among pregnant women and infants, as families are less able to purchase more expensive micronutrient rich foods. Recent surveillance data indicates that the prevalence of night blindness has more than doubled in Central Java in the past year. This disturbing trend is likely to have an impact on pregnancy-related mortality. There is

also evidence that the proportion of infants born with Low Birth Weight has increased in Jakarta and in certain areas of 12 provinces during 1998. Child malnutrition is also increasing significantly, particularly in urban areas and some outer provinces.

- Reduced reliance on modern health care has resulted in higher severity of illnesses and disease.

The increased price for modern medicine and contraceptives combined with the reduced purchasing power of households has caused a significant problem for users who seek health care. There is evidence that use of modern family planning declined by 5-10% in some provinces between January and December 1998. There is also evidence that family planning acceptors are discontinuing use to adopt less costly, but also less effective, traditional family planning methods (i.e., herbal potions). Reductions in contraceptive use are likely to result in increases in pregnancy, including unintended pregnancies. Data collected recently from several clinics in South Sumatra indicate a doubling in the number of patients seeking post-abortion care services between 1997 and 1998. The number of women who are at risk for unwanted pregnancy, unsafe abortion, and maternal mortality has increased since the crisis began.

Recent data indicate that the poor have increasingly shifted to traditional healers rather than modern practitioners for health care and treatment of illness. This is a very serious problem for maternal care. Midwives play a critical role in the MOH strategy for safe motherhood by providing antenatal care, care during labor and delivery, postnatal care, and care of the neonate. As a result of the crisis, more mothers may resort to the services of the traditional birth attendant, rather than incur the cost of using a trained midwife. Critical delays in obtaining emergency obstetric care will be exacerbated as families debate their willingness to spend scarce resources for the management of complications. This may lead to increases in maternal deaths due to lack of proper emergency care.

Delays in seeking health care services for infectious diseases, particularly among young children, will likely result in a higher severity of cases among those who finally do seek care. Lower incomes and higher drug costs also decrease the likelihood that a sick individual will follow a prescribed course of antibiotic treatment, or even have the ability to purchase the full treatment regimen in the first place. There is evidence that the prevalence of certain sexually transmitted diseases has increased from 35% to 45% in the past year. This increase may be the result of delaying costly antibiotic treatments.

- Reduced levels of education attainment have resulted as family members (including children and adolescents) have struggled to generate income. School enrollment levels have decreased so the educational attainment for a generation is likely to fall. This can have long-term consequences on the health status because maternal education has been found to be a strong predictor of reduced fertility as well as the health status of children.

- Reduced ability of families to afford water, sanitation, and decent housing which may result in a higher incidence of infectious diseases among vulnerable population groups.

- Increased levels of high risk behavior, such as engagement in commercial sex, as a necessity prompted by unemployment. Increased participation in the commercial sex industry can lead to increased incidence of sexually transmitted diseases.

The economic crisis has also had a severe impact on *health care* -- the health sector's ability to perform its mission. There is a rapidly widening gap between household resources and government resources available to purchase and provide health care, and the resources that are needed to address the increased health care needs of the population. Moreover, the current health care crisis is being aggravated by sudden outbreaks of diseases and widespread social violence in certain provinces. Finally, in response to the economic and political crisis, the health sector in Indonesia is undertaking a major decentralization reform effort to improve the efficiency of resource allocations and to empower local governments. Given the widening resource gap, as well as sudden political changes, the ability of the public and private sectors to address the health care crisis has been severely curtailed.

- Public sector health care.

The economic crisis has compromised the ability of the Government of Indonesia to finance the health sector. Health expenditure as a percentage of Gross Domestic Product, was already low at 1.6% before the crisis began. As a result of the economic crisis, the Government's allocated budget for health and family planning was reduced significantly last year. Both Indonesia's reliance on imported pharmaceuticals, materials and equipment, and the devaluation of the rupiah have led to at least a three-to-five-fold increase in health care costs. There are decreasing resources to improve quality at all levels of the health care system. Declining budgets have forced cutbacks in routine service delivery operations, such as training, travel and transportation, provision of medical supplies, supervision, and program monitoring. The public sector needs to monitor the effects of the crisis carefully in order to target scarce resources and to design effective crisis- response efforts.

Decentralization is a key reform issue for all sectors, including the population, health and nutrition sector. The economic, political, and humanitarian crisis provides an unprecedented opportunity for USAID to assist the Government of Indonesia to advance the decentralization process now underway. The Ministry of Health is committed to strengthening institutional, management, and technical capabilities of provincial and district health offices and facilities.

- Private sector health care.

*The crisis is also having a severe impact on the viability of the private health care sector.* Private sector investment and revenues have diminished, while the cost of import-dependent drugs and supplies has increased. Lower purchasing power, resulting in a lower demand for private services among certain income groups, as well as higher costs of inputs necessary to provide medical care and the unavailability of investment, all threaten the survival of the private sector.

At the same time, as a result of the nationwide political and democracy reform efforts, there is also an unprecedented opportunity to improve and expand local non-governmental organization involvement in the management and delivery of health services at the community level.

Considered together, the *health crisis* and the *health care crisis* form a widening gap between reduced resources and increased need for health care, creating an increased burden of disease.

**Section 2.2 New Strategic Objective (Summary)**

To help reduce this resource gap, USAID and its implementing partners will work together with the Government of Indonesia to **Protect the Health of the Most Vulnerable Women and Children** during the crisis and recovery period. Activities undertaken to achieve this strategic objective will ensure that:

- essential primary health care services are available and accessible to communities and households;

- surveillance and monitoring systems are in place to foster appropriate responses; and

- information is available and communicated about appropriate health behaviors during this crisis.

Working in collaboration with government and non-governmental partners and other donors, the USAID assistance will support the primary health care service delivery system to prevent further deteriorations in health and nutrition status. The USAID assistance will ensure that utilization of essential services (including family planning, maternal and neonatal health, child health, and prevention of sexually-transmitted infections, including HIV/AIDS), will return to pre-crisis levels and in the longer term, will continue to improve. The USAID assistance will support the Government's decentralization efforts to strengthen the institutional, management, and technical capabilities of provincial and district health offices and facilities. Finally, the USAID assistance will strengthen the management and technical capabilities of local non-governmental organizations in order to improve and expand NGO involvement in the delivery of health services at the community level.